RSC Republican Study Committee
Rep. Jeb Hensarling (R-TX), Chairman
Russ Vought, Executive Director
132 Cannon House Office Building
Washington, DC 20515
www.house.gov/hensarling/rsc
ph (202) 226-9717 / fax (202) 226-1633

# RSC Policy Brief:
# Durable Medical Equipment

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**The RSC has prepared the following policy brief providing background information on the competitive bidding program for durable medical equipment.**

**Background**: In addition to providing coverage for outpatient physician services, Medicare Part B also helps pay for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) needed by beneficiaries. Currently, Medicare reimburses beneficiaries for supplies using a series of fee schedules, which are generally based on historical prices subject to annual updates or other adjustments. Medicare finances 80% of the actual costs or the fee schedule amount, whichever less, with the beneficiary paying the difference. The Centers for Medicare and Medicaid Services (CMS) estimates that about 10 million individuals—or about one-quarter of all beneficiaries—receive medical supplies under Part B in a given year, at a cost to Medicare of approximately $10 billion annually.[1]

In recent years, some conservatives have raised concerns that the prices on the Medicare fee schedule for DMEPOS were in excess of market prices. In 2002, testimony by the Department of Health and Human Services Inspector General revealed that the prices paid by Medicare for 16 selected items of durable medical equipment were higher than prices paid by Medicaid, the Federal Employee Health Benefits (FEHB) plans, and consumers purchasing directly from retailers. The Inspector General projected that using the lower prices by other payers for these 16 common items alone would have saved Medicare more than $100 million annually.[2]

[1] Cited in Government Accountability Office, "Medicare: Competitive Bidding for Medical Equipment and Supplies Could Reduce Program Payments, but Adequate Oversight Is Critical," (Washington, Report GAO-08-767T), available online at http://www.gao.gov/new.items/d08767t.pdf (accessed June 9, 2008), p. 3.
[2] Testimony of Janet Rehnquist, Inspector General of the Department of Health and Human Services, before Senate Appropriations Subcommittee on Labor, HHS, and Education, June 12, 2002 hearing, available online at http://www.oig.hhs.gov/testimony/docs/2002/020611fin.pdf (accessed June 16, 2008).

In response to the above findings, Congress in the Medicare Modernization Act (MMA) of 2003 (P.L. 108-173) enacted cuts in the fee schedule levels for the 16 specific items studied by the Inspector General's testimony, while creating a new competitive bidding process for DMEPOS suppliers in Section 302 of the law. This nationwide program followed on the heels of three demonstration projects, authorized under the Balanced Budget Act of 1997, established during the period 1999-2002 in Florida and Texas. The pilot programs demonstrated the ability of competitive bidding to reduce the costs of DMEPOS by an average 19.1%—saving the federal government $7.5 million, and $1.9 million in reduced beneficiary co-payments—while maintaining beneficiary access to required items.[3]

In addition to a program of competitive bidding for DMEPOS, the MMA also established a new accreditation process for suppliers designed to review suppliers' financial records and other related documentation to establish their status as *bona fide* health equipment suppliers. A November 2007 CMS estimate indicated that 10.3% of payments to medical equipment suppliers were improper—a rate of questionable payments more than double those of other Medicare providers.[4] Coupled with the new competitive bidding program, the accreditation mechanism was intended to eliminate "fly-by-night" DMEPOS suppliers from operating within the Medicare program, and thus was included in the anti-fraud title of MMA.

**Implementation**: CMS previously announced that, pursuant to the Section 302 requirements, Round 1 of the DMEPOS competitive bidding process would begin on July 1, 2008 in ten Metropolitan Statistical Areas (MSAs): Charlotte, Cincinnati, Cleveland, Dallas, Kansas City, Miami, Orlando, Pittsburgh, Riverside, and San Juan. A further 70 MSAs will be included in the program in 2009, with more expected to be included in subsequent years.

The three-year bids for the first round of MSA sites were submitted in September 2007; CMS notified winning bidders, and accepted contracts from winning bidders, earlier this spring. Based on the Round 1 bids, CMS has indicated that the Medicare program and beneficiaries will save an average of 26% in the 10 categories of DMEPOS open to competitive bidding—ranging from a 14% savings on negative pressure wound therapy pumps and supplies to 43% savings on mail-order diabetic supplies. When fully implemented, CMS estimates that competitive bidding will save the Medicare program approximately $1 billion per year.

**Concerns Raised**: The introduction of DMEPOS competitive bidding has not been without controversy, and concerns raised by suppliers and other interested parties have generally fallen into two categories. Some suppliers have raised specific concerns about the way in which CMS' contractor conducted the Round 1 bidding process. Many of these concerns have focused on a lack of communication from the contractor to the suppliers, resulting in some suppliers' bids being rejected for lack of proper financial documentation without the suppliers having an opportunity to provide further information or clarification. CMS has indicated that approximately 16% of all bids submitted were rejected solely due to a failure to meet proper

[3] Testimony of Thomas Hoerger, Senior Fellow, Research Triangle Institute International, before House Ways and Means Subcommittee on Health, May 6, 2008 hearing on Durable Medical Equipment Competitive Bidding, available online at http://waysandmeans.house.gov/hearings.asp?formmode=printfriendly&id=6906 (accessed June 9, 2008).
[4] Cited in Government Accountability Office, "Medicare Competitive Bidding," pp. 10-11.

qualification criteria; by contrast, 61% of all bids submitted were priced outside the winning range.

In response to the concerns raised regarding qualification criteria, CMS has utilized a twin-stage process of review for Round 1 suppliers who raised protests about the way the contractor conducted the bid process. Both the contractor and CMS have taken steps to re-examine the documentation submitted during the review process, and in some cases, CMS has allowed those suppliers with winning bids who failed to meet accreditation or related requirements due to a lack of communication from the contractor to participate in the Round 1 location areas. In addition, CMS has extended the accreditation deadline for suppliers participating in Round 2 bidding, and will also seek input from the Program Oversight and Advisory Committee established under the MMA for ways to refine and improve the DMEPOS competitive bidding process for subsequent bidding rounds.

The second group of concerns are broader in scope, and go to the heart of the competitive bidding program itself. Concerns in this line include the potential impact on suppliers, particularly small businesses, who were not successful on pricing grounds. Some policy-makers have also questioned the lack of scrutiny given to subcontractors not subject to the same accreditation requirements as DMEPOS contractors. Lastly, other groups have questioned whether competitive bidding will lead to the sale of lower quality supplies and equipment to beneficiaries, as well as whether beneficiaries will be able to obtain access to DMEPOS equipment in instances where the winning bidders in an MSA had not previously serviced the area in question.

Some conservatives may question the need to delay the competitive bidding process on these grounds. CMS provided specific opportunities for small businesses to participate in the DMEPOS competitive bidding process, resulting in approximately half of firms who accepted winning bids having revenues of less than $3.5 million. These small business opportunities occurred in the context of a market-oriented bidding mechanism that, when fully implemented, will save taxpayers approximately $1 billion annually—and will provide additional savings to Medicare beneficiaries in the form of reduced co-payments. In addition, the accreditation mechanism established by Section 302 of MMA provides a quality check previously lacking for DMEPOS purchases and suppliers.

While transitioning to a new system can create logistical difficulties, the staged implementation process will ensure that beneficiaries in a limited number of areas—only one-quarter of whom receive DMEPOS supplies in a given year—will experience the transition to a competitively bid environment this year. This phased-in approach stands in contrast to the January 1, 2006 implementation of the Medicare Part D prescription drug benefit, where tens of millions of beneficiaries received new coverage at a single point in time—with logistical obstacles, though significant, relatively minor on a percentage basis.

**Legislative Status**: On June 12, 2008, House Ways and Means Health Subcommittee Chairman Pete Stark (D-CA) and Ranking Member Dave Camp (R-MI) introduced H.R. 6252, the Medicare DMEPOS Competitive Acquisition Reform Act. The legislation would terminate all Round 1 contracts made pursuant to the round of competitive bidding completed this spring, and

would direct CMS to re-bid Round 1 at some point during 2009. Future rounds of competitive bidding would also be delayed, with Round 2 (featuring an additional 70 MSAs) taking place during 2011, and competitive bidding in rural areas and smaller MSAs being delayed until 2015. The estimated $3 billion cost of the delay would be paid for by an across-the-board reduction of 9.5% for all DMEPOS scheduled to be subjected to competitive bidding. In addition, the bill would require the CMS contractor to notify suppliers missing financial documentation related to their bids, extend disclosure and accreditation requirements to DMEPOS sub-contractors, and establish an ombudsman within CMS to respond to complaints from suppliers and individuals about the DMEPOS competitive bidding process.

While competitive bidding language was not included in the Medicare legislative package (S. 3101) on which the Senate failed to achieve cloture last week, Finance Committee Chairman Baucus and Ranking Member Grassley have discussed incorporating language delaying the competitive bidding process into their competing packages covering an adjustment to Medicare physician reimbursement levels.

**Implications of Delay**: Despite the contracting problems that have led some contractors to raise legitimate process concerns about the implementation of the first bidding round, some conservatives may still be concerned about the implications of the proposed legislative delay, particularly if coupled with a mandate that CMS re-bid the first round of DMEPOS bidding. Re-opening the bidding process could prejudice entities who won their bids earlier this year, while potentially reducing savings to the federal government by allowing suppliers to bid more strategically, having had experience with the winning range of bids during the initial round.

In addition, some conservatives may be concerned that a delay of more than a few months would result in a new Administration being charged with implementation of competitive bidding, which could allow for further opportunities to undermine the program through the regulatory process. Chairman Stark has indicated his desire to abolish the competitive bidding program altogether, paid for by the across-the-board cut in DMEPOS reimbursement levels currently being contemplated—so it is entirely possible that a new Administration and a future Congress could decide to make the "temporary" delay permanent and abolish competitive bidding outright.

**Conclusion**: The debate surrounding DMEPOS competitive bidding finds many medical suppliers—some with understandable concerns about a lack of communication from the bidding contractor, others merely disappointed in not achieving a winning price for their bid—seeking redress from Congress for a bidding mechanism Congress established with the intent of creating arm's-length transactions between the agency purchasing goods (i.e. CMS) and private suppliers. Yet the alternative to a competitive bidding system where markets set prices for DMEPOS involves arbitrary reductions to inherently arbitrary fee schedules enacted by policy-makers with little proficiency in the minutiae of the myriad health care services for which the federal government acts as a payer. As Senate Finance Committee Chairman Baucus conceded at a health care summit: "How in the world am I supposed to know what the proper reimbursement should be for a particular procedure?"[5]

[5] Quoted in Anna Edney, "Bernanke: Health Care Reform Will Require Higher Spending," *CongressDailyPM* June 16, 2008, available online at http://www.nationaljournal.com/congressdaily/cdp_20080616_8602.php (accessed June 16, 2008).

For this reason, some conservatives may object to Congress' frequent attempts to litigate these types of disputes, and may view the controversy surrounding DMEPOS competitive bidding as emblematic of larger problems with the current entitlement system. In the myriad debates which it is perpetually pressured to referee—from the sustainable growth mechanism (SGR) to reimbursement levels for hospitals and nursing homes to the levels of epogen provided to kidney dialysis patients—Congress' firsthand expertise is as limited as its jurisdiction is absolute. The end result has frequently been an imbalance of attention paid to various reimbursement "crises," with only secondary consideration given to the longer-term health and solvency of the underlying entitlement programs (i.e. Medicare and Medicaid) in question.

Some conservatives may believe that the lesson from these past and current controversies is that Congress has a poor track record in adjudicating provider-related disputes. Many may find a better solution in a premium support mechanism that would convert Medicare into a system similar to the Federal Employees Benefit Health Plan (FEHBP), in which beneficiaries would receive a defined contribution from Medicare to purchase a health plan of their choosing. In addition to ensuring long-term fiscal stability by confining the growth of Medicare spending to the annual statutory raise in the defined contribution limit, a premium support mechanism would result in reimbursement decisions being made by private insurance carriers, obviating the need for Congress to micro-manage provider payment levels. Such a solution would provide a meaningful reform to the underlying problems that have erupted most recently in the DMEPOS competitive bidding controversy, by saving providers from the whims of Congress—and saving Congress from itself.

For further information on this issue see:

- *CMS Website on DME Competitive Bidding Process*
- *May 2008 House Ways and Means Health Subcommittee Hearing on DME Competitive Bidding*
- *Government Accountability Office Report on DME Competitive Bidding*

**RSC Staff Contact**: Chris Jacobs, christopher.jacobs@mail.house.gov, (202) 226-8585

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